

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001679

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED:

Registration District No.

149

Primary Registration District No.

002

Registrar's No.

292

STATE FILE NUMBER

## 1. PLACE OF DEATH

a. COUNTY

Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR  
TOWN

Kansas City

Length of stay in 1b

6 yrs.

c. FULL NAME OF (If not in hospital, give location)  
HOSPITAL OR  
INSTITUTION

General Hospital

Inside Limits  
Yes ☐ No ☐

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MO

b. COUNTY

Jackson

c. CITY  
OR  
TOWN

Kansas City

Inside Limits  
Yes ☐ No ☐d. STREET  
ADDRESS(If outside, give location)  
6225 E. 14thReside on Farm  
Yes ☐ No ☐3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

Earl

Sullivan

Giddens

4. DATE  
OF  
DEATH

Month

Day

Year

1

15

62

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. Married ☒ Never Married ☐  
Widowed ☐ Divorced ☐

## 8. DATE OF BIRTH

2/4/1902

## 9. AGE (last birthday)

59

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HR

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook

## 10b. KIND OF BUSINESS OR INDUSTRY

Restaurant

## 11. BIRTHPLACE (City and state or country)

Rockface, Ga

## 12. CITIZEN OF WHAT COUNTRY

## 13a. FATHER'S NAME

Roy A. Giddens

## 13b. MOTHER'S MAIDEN NAME

Lutisha Lyke

## 14. NAME OF HUSBAND OR WIFE

Marie S. Giddens

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, unknown) (If yes, give war or dates of service)

Yes, WW I

## 16. SOCIAL SECURITY NO.

[REDACTED]

## 17. INFORMANT

Marie Giddens

## Address

P.O. Box 1514  
Rockface, Ga18. CAUSE OF DEATH (Enter only one cause per line  
PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

Myocardial Infarction

INTERVAL BETWEEN  
ONSET AND DEATHConditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

## DUE TO (b)

## DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal  
disease condition given in PART I (a)PART III. If deceased was female was  
there a pregnancy in last 90 days☐ Yes☐ No☐ Unknown19. WAS AUTOPSY  
PERFORMED?  
YES ☒ NO ☐

## 20a. ACCIDENT

## SUICIDE

## HOMICIDE

☐ ☐ ☐

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF  
INJURYHour  
a.m.  
p.m.

## Month, Day, Year

20d. INJURY OCCURRED  
WHILE AT WORK ☐  
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,  
farm, factory, street, office bldg., etc.)

## 20f. CITY, TOWN, OR LOCATION

## COUNTY

## STATE

## 21. I attended the deceased from 1-10-62 to 1-15-62 and last saw him alive on 1-15-62

Death occurred at 5:20 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

(Degree or title)

## 22b. ADDRESS

## 22c. DATE SIGNED

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

## 23b. DATE

## 23c. NAME OF CEMETERY OR CREMATORY

## 23d. LOCATION (City, town, or county)

(State)

## 24. FUNERAL DIRECTOR

## ADDRESS

## 25. DATE RECD. BY LOCAL REG.

## 26. REGISTRAR'S SIGNATURE

C. H. Blackmon R.C., Mo

1-17-62

Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Bert B. Bennett

Licensed Embalmer No. 4656

P. O. Address K. C., Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.